STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC # 1	445245	A. BUILDING _____ B. WING _____	C 10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MARYVILLE	1012 JAMESTOWN WAY MARYVILLE, TN 37803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to answer the call light in a timely manner for one resident (#12) of thirteen residents reviewed. The findings included: Resident #12 was admitted to the facility on July 30, 2012 with diagnoses including Atrial Fibrillation, Congestive Heart Failure, Valvular Heart Disease, Hypertension, Gastrointestinal Reflux Disease, Osteoarthritis, Sleep Apnea, Chronic Venous Insufficiency, Diabetes, Morbid Obesity, Right Fibula Fracture and Severe Degenerative Joint Disease of the knee. Medical record review of the Minimum Data Set dated August 6, 2012 revealed the resident scored 15/15 on the Brief Interview for Mental Status (BIMS) with no short or long-term memory problems and no impairment of decision-making skills; had no behaviors or psychosocial concerns; was totally dependent on staff for transfers; required extensive assistance with dressing, hygiene and bathing; and had an	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F-246 Resident #12 is currently using the bedpan. Interviews conducted with the resident by our Care Plan coordinator on October 6, and October 8, 2012 indicates that the staff are meeting her toileting needs. The Care plan has been reviewed on October, 6, 2012 by our Care Plan coordinator to ensure that the resident toileting needs are indicated. The Facility has conducted call light reposne/monitoring audit for 5 days to determine the average length of time for call light response. As a result of the audit all facility employees and new hires of our center will sign a call- light pledge to commit to answering call- lights, whenever they come upon one on, regardless of the department to ensure a multidisciplinary approach. This in-service/pledge will be completed by the SDC/ADNS/DNS/ED or designee on October 17, October 18, 2012, October 24 and October 25, 2012. Call lights will be monitored for response time randomly during daily rounds each month beginning October 1, 2012 for 3 months then quarterly on each nursing to floor to ensure the average call light	10/26/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Mardwell	Executive Director	10/11/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MARYVILLE	1012 JAMESTOWN WAY MARYVILLE, TN 37803

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F 246	Continued From page 1 indwelling urinary catheter. Medical record review of the care area assessment summary dated August 10, 2012 revealed "Resident has a foley catheter (indwelling urinary catheter). Does not have a justification. Referred to MD (Medical Doctor) for reason for foley. Unable to toilet indep. (independently). If foley D/C'd (discontinued), bedpan will have to be used...able to call for assist PRN (as needed)..." Medical record review of a physician's order dated September 5, 2012 revealed "Clamp foley for 4 (hours) & (and) release for 4 (hours) x (times) 48 (hours). Remove F/C (foley catheter) 9/7/12." Medical record review of a nurse's note dated September 7, 2012 revealed the foley catheter was removed and discontinued. Medical record review of nurses' notes dated September 8-23, 2012 revealed the resident was alert, oriented and able to report needs. Observation from the hallway on September 25, 2012 at 1:40 p.m. revealed the resident's call light was on. Observation and interview on September 25, 2012 at 1:41 p.m. revealed the resident lying in bed. Interview with the alert and oriented resident revealed the resident was in need of the bedpan and revealed the resident had turned on the call light to get assistance with the bedpan fifteen to twenty minutes earlier. Continued interview revealed a male Certified Nursing Assistant	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* response is within 2-3 minutes. If the average response time is not adequate after review of call-light audits then resident interviews will also be conducted to determine resident satisfaction with call light response times. Staff education will occur when call light audits and resident interviews reflect call light response time needs improved. Call light audits and staff education, if needed, will be presented to the facility Performance Improvement committee monthly beginning for the month of October 2012. Results of the audits and education will be reviewed and analyzed for recommendations by the committee for appropriate intervention.	

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F 246	Continued From page 2 (CNA) #4 had entered the room and the resident requested a female CNA. Continued interview revealed no staff had returned to place the resident on the bedpan. Interview on September 25, 2012 at 1:43 a.m. with the resident's roommate (#13) who was alert and oriented confirmed resident #12 had been waiting fifteen to twenty minutes for the bedpan. Interview on September 25, 2012 at 1:45 p.m. with CNA #6 in the resident's room revealed CNA #6 had "just clocked in from lunch." Observation revealed CNA #6 began assisting the resident onto the bedpan. Interview on September 25, 2012 at 1:46 p.m. in the hallway of the 200 unit with CNA #4 (male) confirmed CNA #4 reported to CNA #5 (female CNA) that the resident needed placed on the bedpan and CNA #5 responded by saying she and CNA #6 would "do it" when CNA #6 returned from lunch. Interview on September 25, 2012 at 1:50 p.m. with CNA #5 confirmed CNA #4 reported the resident requested the bedpan but the only CNAs on the unit were CNA #4 (male) and CNA #5 (female). Continued interview confirmed the resident had to wait to be placed on the bedpan until CNA #6 returned from lunch. Continued interview with CNA #6 confirmed the CNA had "no idea" how long the resident had waited for assistance onto the bedpan.	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 280 SS=D	C/O #30320 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F- 280 Resident 3# Care Plan was updated on September 28, 2012. A review of the	

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F 280	Continued From page 3 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update the care plan to include supervision of one resident (#3) with a history of falls of thirteen residents reviewed. The findings included: Resident #3 was admitted to the facility on August 19, 2010 with diagnoses including Dementia, Urinary Tract Infection, Arthritis, History of Deep Vein Thrombosis (blood clot) and Alzheimer's Disease.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Care Plan on October 6, 2012 indicates recommended supervision when resident is up in wheel chair and going to and from activities has been updated by our Care Plan Coordinator. All resident with falls in the last 60 days will be reviewed to ensure appropriate interventions are in place, care plans reflect the most current interventions and such interventions are in use by October.26, 2012. Educational in-services will be conducted by the Staff Development Coordinator or designee on monitoring residents for safety, knowledge of and effectiveness of interventions that have been identified as needing supervision when up in wheelchairs and completed by October 17, October 18, 2012 and October 24, October 25, 2012. Fall Interventions, to include Safety devices, will be monitored daily by nursing supervisors during walking rounds and the safety device log reviewed weekly at the facility Standards of Care meeting beginning the week of October 8, 2012. Activity staff and Therapy staff will be educated on supervision of residents to and from activities by Rehabilitation manager and	10/26/12

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F 280	Continued From page 4 Medical record review of the Minimum Data Set (MDS) dated May 22, 2012 revealed the resident had short and long-term memory problems and severely impaired decision making skills; required extensive assistance for transfers and activities of daily living; and had a fall with minor injury. Medical record review of the fall risk assessments dated January 10, 2012 and February 29, 2012 revealed the resident was assessed with a fall risk of "80" (45 and higher=high risk). Medical record review of the fall risk assessment dated April 15, 2012 revealed a fall risk of "90." Medical record review of nurses' notes revealed the following: May 31, 2012-"Up in w/c (wheelchair) very restless, agitated @ (at) times"; June 6, 2012-"...many attempts @ ambulating & (and) getting out of bed during the night..." and June 6, 2012-"...Very restless this shift, standing up attempting to walk every few minutes..." Medical record review of a nurse's note dated June 7, 2012 at 11:00 a.m. revealed "Res. (Resident) was pushed in w/c by activity staff back to unit after being at church activity in main dining room. Sitting in w/c (with) alarm in place in hallway at nurses(') desk. Res. fell asleep & tumbled from chair hitting forehead on floor. This nurse called from med room to assess. ROM (Range of motion) to upper & lower extremities WNL (within normal limits). (No) injuries of extremities noted at this time, will cont. (continue) to monitor. Hematoma noted on forehead, red/purple in color, raised (with) small abrasion in center. No bleeding noted of area. When asked if...hurts stated "just my forehead." Given PRN (as needed) Tylenol. Drowsy but opens eyes to	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Activities Director October 11, and October 12, 2012. Updates will be provided on going at each Standards of Care meeting by nurse supervisors beginning the week of October 8, 2012. Fall intervention safety device monitoring logs and resident events will be submitted to the facility performance improvement committee monthly beginning with the October 2012 meeting for review. Results of the review will be analyzed for trends and recommendations made by the committee for appropriate intervention to the Interdisciplinary Team.	

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F 280	Continued From page 5 stimulus..." Medical record review of a post fall evaluation dated June 7, 2012 revealed "...Immediate Interventions taken to protect the resident: always place res where staff present, in dayroom or nurses desk...resident must be where staff is present to be monitored..." Medical record review of the care plan updated August 22, 2012 revealed no interventions were included related to placement of the resident in areas where supervision and monitoring could be provided when the resident was in the wheelchair. Telephone interview on September 27, 2012 at 2:00 p.m. with Registered Nurse (RN) #1/Care Plan Coordinator confirmed RN #1 reviewed the care plan which was updated August 22, 2012 and confirmed the care plan had not been updated to include placement of the resident in areas where supervision and monitoring could be provided when the resident was in the wheelchair.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 312 SS=D	C/O #29997 and #30123 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation	F 312	F- 312 Resident 7# ADL (activities of daily living) care was completed by C.N.A. (Certified Nursing Assistant) 1#, C.N.A. 2# and C.N.A. 3# as directed and confirmed by DON on September 24, 2012 by 10:45 a.m. Resident 7# has been referred to therapy on September 25, 2012 to screen for positioning and assistance recommendations. Resident 7# Care plan has been reviewed for ADL assistance and updated as of October 6, 2012	

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F 312	Continued From page 6 and interview, the facility failed to ensure personal care was provided in for one (#7) of thirteen residents reviewed. The findings included: Resident #7 was admitted to the facility on February 18, 2005 with diagnoses including Schizophrenia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Anxiety and Convulsions. Medical record review of the Minimum Data Set (MDS) dated September 25, 2012 revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADL); and was incontinent of bowel and bladder. Observation and interview on September 24, 2012 at 10:37 a.m. in the resident's room revealed the resident lying in bed and covered with a sheet which was wet on the left side from the neck to below the waist and stained with a light brown liquid. Interview with the resident at the time of the observation confirmed coffee from the breakfast meal had been spilled on the sheet. Observation and interview on September 24, 2012 at 10:38 a.m. revealed Certified Nursing Assistant (CNA) #1 entered the resident's room; identified self as the Scheduling Coordinator; and reported CNA #1 was "going to clean (resident) up and change (resident's) bed." Observation revealed CNA #2 and #3 entered the room to assist CNA #1. Observation revealed the resident was positioned on the right side and the	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Residents that are incontinent will be assessed by nurse managers to ensure incontinent briefs are properly sized and fitted to the individual resident by October 26, 2012. Care plans will be reviewed and updated to reflect correct incontinent brief and frequency of rounds which will be at a minimum conducted every 2 hrs. Based on results of the rounds the frequency of "check & change" will be updated to meet each individual residents "pattern" as a result being performed more frequently than every 2 hours. And the care plan and CNA assignment sheet will be updated accordingly. Walking rounds will be conducted 2 -3 times daily by Nurse Supervisors and/or Charge nurse to monitor/audit residents that are incontinent to ensure their ADL (activities of daily living) needs are being met timely beginning October 8, 2012. Results of the walking rounds will be reviewed by our Interdisciplinary Team weekly to ensure proper disposable or cloth products are being used and each resident is being changed timely.	10/26/12

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F 312	Continued From page 7 brief was removed. Observation revealed CNA #1 described the resident as "soaked" with urine and the sheet covering the resident was wet. Interview with CNA #1 at the time of the observation confirmed the resident was in need of incontinence care and a linen change. Interview on September 25, 2012 at 4:45 p.m. in the Director of Nursing's (DON) office with the DON revealed the DON had observed the resident in the a.m. of September 24, 2012 with a wet sheet covering the resident and confirmed CNA #1 was directed to provide care to the resident after the DON's observation. C/O #29997, #30123, #30230	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Resident Care Plan Coordinator or designee will present the results of walking rounds and resident interviews by our nurse managers and charge nurses monthly to the facility Performance Improvement Committee for trends and recommendations beginning with the October 2012 meeting.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure supervision was provided to prevent a fall for one resident with a history of falls with injury (#3) and failed to complete the fall risk assessment for one (#4) after a fall of thirteen residents reviewed.	F 323	F- 323 Resident 3# Care Plan was updated on September 25, 2012. A review of the Care Plan on October 6, 2012 indicates recommended supervision when resident is up in wheel chair and going to and from activities. Resident 4# has been discharged from the center. All resident that has been assessed as high risk for falls on their most recent fall risk assessment will be reviewed to ensure each is fully completed by October 26, 2012. Care Plans, for high risk assessed residents will be reviewed by October 26, 2012 and ensure that approaches to include all safety devices, interventions and monitoring are current or updated as necessary.	10/26/12

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F 323	Continued From page 8 The findings included: Resident #3 was admitted to the facility on August 19, 2010 with diagnoses including Dementia, Urinary Tract Infection, Arthritis, History of Deep Vein Thrombosis (blood clot) and Alzheimer's Disease. Medical record review of the Minimum Data Set (MDS) dated May 22, 2012 revealed the resident had short and long-term memory problems and severely impaired decision making skills; required extensive assistance for transfers and activities of daily living; and had a fall with minor injury. Medical record review of the fall risk assessment dated January 10, 2012 and February 29, 2012 revealed the resident was assessed with a fall risk of "80" (45 and higher=high risk). Medical record review of the fall risk assessment dated April 15, 2012 revealed a fall risk of "90." Medical record review of nurses' notes and post fall evaluations and investigations revealed the resident had the following falls: September 28, 2011 resulting in a fractured pelvis; November 10, 2011 with minor injuries; January 9, 2012 from the bed and February 29, 2012 from the wheelchair and no injuries with either fall; February 3, 2012 (location unknown) and April 15, 2012 from the wheelchair and minor injury with each fall. Medical record review of nurses' notes dated April 15, 2012 revealed the resident was evaluated in the emergency room after the fall at the family's request; assessed to have no fractures; and was returned to the facility. Medical record review of nurses' notes revealed	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Educational in-services will be conducted by the center on completing the fall risk assessment by our Staff Development Coordinator or designee on October 16, and October 19, 2012 for Licensed staff. Safety devices/interventions will be monitored daily by nursing supervisors during walking rounds and reviewed weekly at the facility Standards of Care meeting beginning October 8, 2012. Activity staff and Therapy staff will be educated on supervision of residents to and from activities by Rehabilitation manager and Activities Director on October 11, and October 12, 2012. Updates will be provided to Activity and Therapy staff at each Standards of Care meeting by nurse supervisors beginning the week of October 8, 2012. Safety device/intervention monitoring logs and resident events will be submitted by the DNS to the facility performance improvement committee monthly beginning with the October 2012 meeting for review. Results of the review will be analyzed for trends and recommendations made by the committee for appropriate intervention to the	

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KINDRED NURSING AND REHABILITATION-MARYVILLE	1012 JAMESTOWN WAY MARYVILLE, TN 37803

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F 323	Continued From page 9 the following: May 31, 2012-"Up in w/c (wheelchair) very restless, agitated @ (at) times"; June 6, 2012-"...many attempts @ ambulating & (and) getting out of bed during the night..." and June 6, 2012-"...Very restless this shift, standing up attempting to walk every few minutes..." Medical record review of a nurse's note dated June 7, 2012 at 11:00 a.m. revealed "Res. (Resident) was pushed in w/c by activity staff back to unit after being at church activity in main dining room. Sitting in w/c (with) alarm in place in hallway at nurses(') desk. Res. fell asleep & tumbled from chair hitting forehead on floor. This nurse called from med room to assess. ROM (Range of motion) to upper & lower extremities WNL (within normal limits). (No) injuries of extremities noted at this time, will cont. (continue) to monitor. Hematoma noted on forehead, red/purple in color, raised (with) small abrasion in center. No bleeding noted of area. When asked if...hurts stated "just my forehead." Given PRN (as needed) Tylenol. Drowsy but opens eyes to stimulus..." Observation on September 24, 2012 at 12:03 p.m. revealed the resident sitting in a geri chair in the dining room with the head down and the eyes closed. Observation revealed staff were present in the dining room. Observation on September 25, 2012 at 2:00 p.m. revealed the resident sitting in the activity room working a puzzle with a Certified Nursing Assistant present. Interview on September 25, 2012 at 2:35 p.m. on the 100 unit with Licensed Practical Nurse (LPN)	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Interdisciplinary Team. Performance Improvement Committee (PI) Administrator, DNS, Director of Social Services, Social Worker, Staff Development Coordinator, Registered Dietician, Plant Operations Dir.,Case Manager, Activity Director, Business Office Mgr. Medical Director, Pharmacy Consultant, Asst. Director of Nursing, Nurse Manager Standards of Care Committee (SOC) DNS, Director of Social Services, Social Worker, Staff Development Coordinator, Registered Dietician, Asst. Director of Nursing, Nurse Manager, Care Plan Coordinator, MDS Nurses Interdisciplinary Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445245	A. BUILDING _____ B. WING _____	C 10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 10 #1 confirmed staff had knowledge the resident was at high risk for falls and confirmed the resident required "constant supervision". Continued interview confirmed if the resident was not in an activity with supervision the resident was kept at the nurses' station for supervision. Telephone interview on September 27, 2012 at 1:05 p.m. with the Director of Nursing (DON) confirmed the activity staff returned the resident to the unit after an activity on June 7, 2012 and failed to inform staff the resident was back on the unit prior to the fall on June 7, 2012. Resident #4 was admitted to the facility on February 2, 2011 with diagnoses including Upper Gastrointestinal Hemorrhage, Aspiration Pneumonia, Acute Renal Failure, Pulmonary Edema, Congestive Heart Failure, Moderate Aortic Stenosis, Hypertension, Atrial Fibrillation, Anemia, Gout, Peripheral Vascular Disease and Dementia. Medical record review of a nurse's note dated June 13, 2012 at 7:55 a.m. revealed the resident fell in the bathroom; had a skin tear to the left forearm; and no other injuries were noted. Medical record review of the fall risk assessment dated June 13, 2012 revealed the assessment was incomplete and did not include documentation of previous falls; secondary diagnoses which could have attributed to the fall; and the resident's fall risk level. Telephone interview on October 1, 2012 at 9:45 a.m. and review of the fall risk assessment dated June 13, 2012 with the Director of Nursing	F 323		

OCT 12 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 11 confirmed the fall risk assessment was incomplete. C/O #29997, #30123	F 323		

OCT 12 2012